State of Connecticut
Office of Managed Care Ombudsman
P.O. Box 1543
Hartford, Connecticut 06144

OFFICE OF MANAGED CARE OMBUDSMAN

Highlights of the Utilization Review Law

According to the Connecticut General Statutes, Section 38a-226*, utilization review means the prospective or concurrent assessment of the necessity and appropriateness of the allocation of health care resources and services proposed to be given or given to an individual within this state.

In summary, a utilization review company must meet the following requirements:

- Must provide notification of any prospective determination by mail or otherwise communicate to the provider of record or the enrollee within two business days of the receipt of all information necessary to complete the review [*Sec.38a-226c(a)(1)(A)*]. Must provide an authorization number if the determination is approved [*Sec.38a-226c(a)(1)(D)*].
- May not retrospectively deny such determination if an admission, service, procedure or extension of stay has taken place after a prospective approval determination has been authorized and communicated [*Sec.38a-226c(a)(1)(A)*].
- Must provide notification of a concurrent determination by mail or otherwise communicate to the provider of record within two business days of receipt of all information necessary to complete the review or, provided all information necessary to perform the review has been received, prior to the end of the current certified period [*Sec.38a-226c(a)(1)(B)*].
- Must provide any determination not to certify an admission, service, procedure or extension of stay in writing [*Sec.38a-226c(a)(1)(E)*].
- Must allow a minimum of twenty-four hours following an emergency admission, service or procedure for an enrollee or his representative to notify the utilization review company and request certification or continuing treatment of that condition [*Sec.38a-226c(a)(10)*].

A utilization review company issuing a case denial:

- Must provide, in writing, any notice of a determination not to certify an admission, service, procedure or extension of stay. This notification must also include the principal reason(s) for the determination and the procedures to initiate an appeal of the determination or the name and telephone number of the person to contact with regard to an appeal [*Sec.38a-226c(a)(1)(E)*].
- Can deny certification if the provider of record fails to provide all relevant information necessary for the utilization review company to certify the admission, procedure, treatment or length of stay [*Sec.38a-226c(c)*].

Highlights of the Utilization Review Law (cont.)

In cases where a decision has been appealed, a utilization review company:

- Must notify, in writing, the enrollee and provider of record of its determination on the appeal as soon as practical, but in no case later than thirty days after receiving the required documentation on the appeal [*Sec.38a-226c(a)(2)(A)*].
- Must ensure that all determinations not to certify an admission, service, procedure or extension of stay shall be made by a licensed practitioner of the medical arts [*Sec.38a-226c(a)(2)(B)*].
- Must assure that a practitioner in a specialty related to the condition is reasonably available to review the case where a denial is upheld on appeal [*Sec.38a-226c(a)(2)(B)(7)*].
- When the reason for the determination not to certify is based on medical necessity, including whether a treatment is experimental or investigational, each utilization review company shall have the case reviewed by a physician who is a specialist in the field related to the condition that is the subject of the appeal. The review shall be completed within thirty days of the request for review [*Sec.38a-226c(a)(2)(B)(7)*].

In certain situations when the appeals process can be expedited, a utilization review company:

- Must provide for an expedited appeals process for emergency or life threatening situations. The adjudication of such expedited appeals must be completed within two business days of the date the appeal is filed and when all information necessary to complete the appeal has been received [*Sec.38a-226c(a)(2)(B)(4)*].
- When an attending physician at an acute care hospital determines that the patient's life will be endangered or other serious injury or illness could occur if the patient is discharged or if treatment is delayed, the attending physician may request an expedited review from the utilization review company. If the attending physician receives no response from the utilization review company after three hours from the time of the request, the request shall be deemed approved. Each utilization review company shall make review staff available from 8:00 a.m. to 9:00 p.m. to process such requests [*Sec.38a-226c(e)*].

If you have any questions or need assistance with an appeal, contact the **Office of Managed Care Ombudsman** toll-free at **1 (866)-HMO-4446** or at **managedcare.ombudsman@po.state.ct.us**

** This summary provides an overview of the General Statutes of Connecticut, Section 38a-226 and should be used only as an educational tool.*